



TEACHING HEALTH CENTER GRADUATE MEDICAL EDUCATION (THCGME) COST EVALUATION UPDATE

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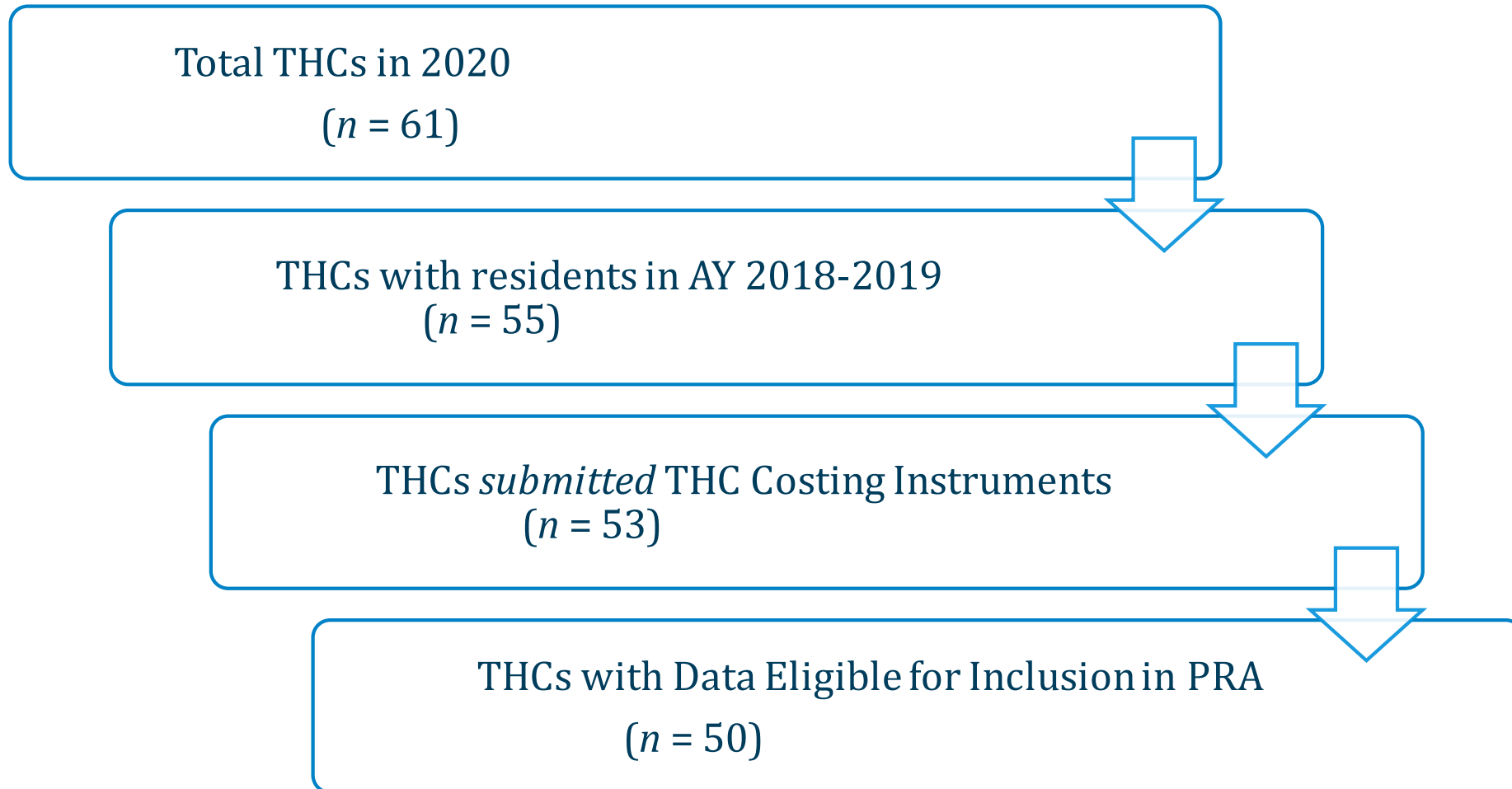
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BACKGROUND

- THCGME Program Cost Evaluation, 2016
 - GW modeled current project on general approach used in first cost evaluation: PRA estimated to be \$157,602 for FY 2017¹
- Current THCGME Cost Evaluation
 - Develop an updated Per Resident Amount, including DME and IME formulas, for AY 2022-2023 (including update factor)
 - THC program more mature now, larger sample (55 THCs)
 - More robust and comprehensive data collection and validation process used in current evaluation
 - Update and streamline THC Costing Instrument (OMB approved 10/6/2020)
 - Collect and analyze expense and revenue data
 - Validate data through external accounting experts
 - Identify characteristics of THCs or sponsoring organizations for potential adjustments to DME and/or IME formulas

¹ Regenstein, M., Nocella, K., Jewers, M. M., & Mullan, F. (2016). The Cost of Residency Training in Teaching Health Centers. *The New England journal of medicine*, 375(7), 612-614. <https://doi.org/10.1056/NEJMp1607866>

THC SAMPLE – 96.4 PERCENT RESPONSE RATE



MULTI-STAGE DATA COLLECTION AND VALIDATION PROCESS

- Used an established data collection tool, tested in prior evaluation (Regenstein et al., 2018)², updated and streamlined for current cost evaluation
- Reviewed submitted costing instruments on a line-by-line basis and resolved data issues with THCs prior to conducting in-depth virtual site visits
- Conducted external data validation process as new component of the current evaluation, not used in the 2016 THCGME study

² Regenstein, M., Snyder, J. E., Jewers, M. M., Nocella, K., & Mullan, F. (2018). Comprehensive Revenue and Expense Data Collection Methodology for Teaching Health Centers: A Model for Accountable Graduate Medical Education Financing. *Journal of graduate medical education*, 10(2), 157–164.
<https://doi.org/10.4300/JGME-D-17-00542.1>

PROJECT GOALS AND KEY DECISION POINTS

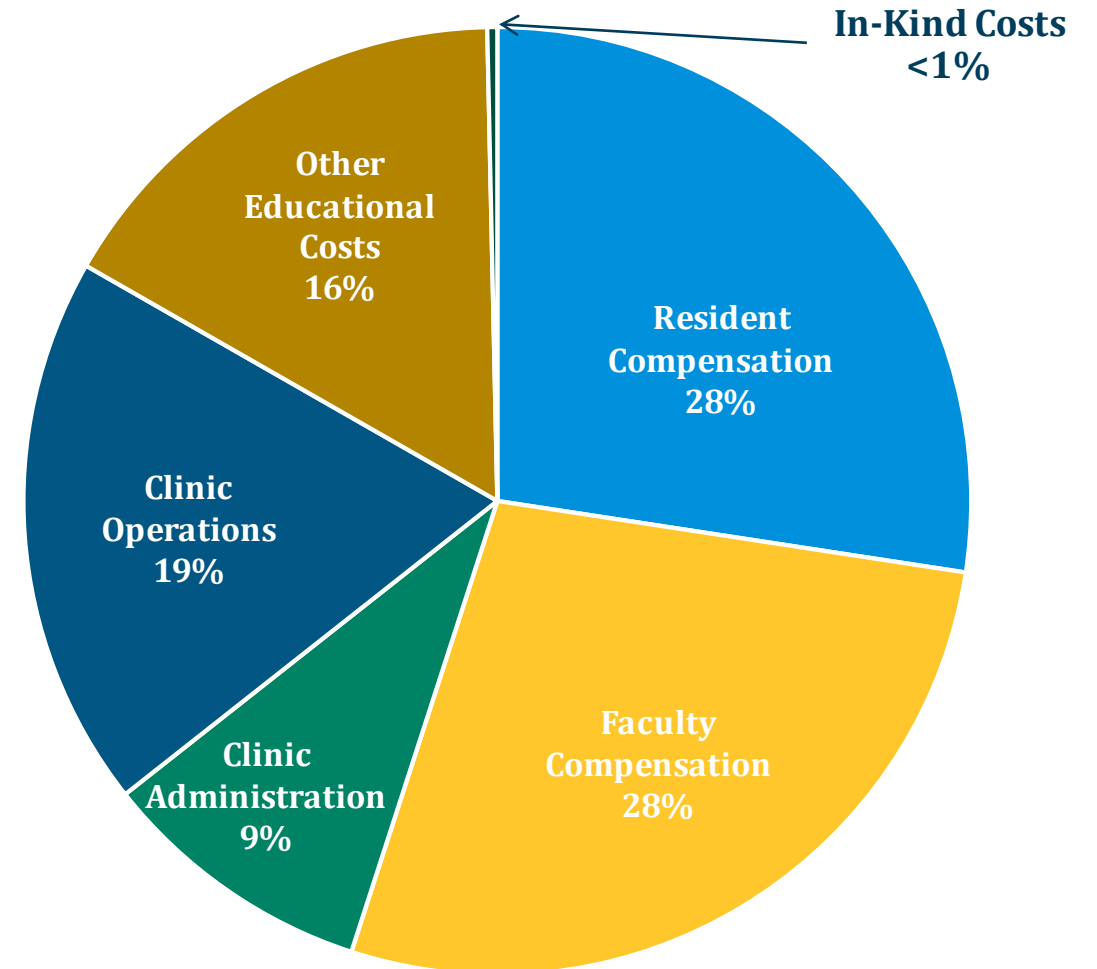
- Core goal: Identify full set of costs of training a resident
 - Conducted in-depth literature review and qualitative interviews with programs to inform current evaluation
 - Collected data for AY 2018-2019 to avoid distortions from COVID-19
 - Included in-kind costs into PRA estimate
 - Excluded HRSA unallowable costs (e.g. meals, graduation costs)
 - Included apportioned continuity clinic revenue and associated clinic administrative and operations expenses

Distribution of Expenses Associated with Residency Training (AY 2018-2019)

Median Expenses Per Resident: \$258,131

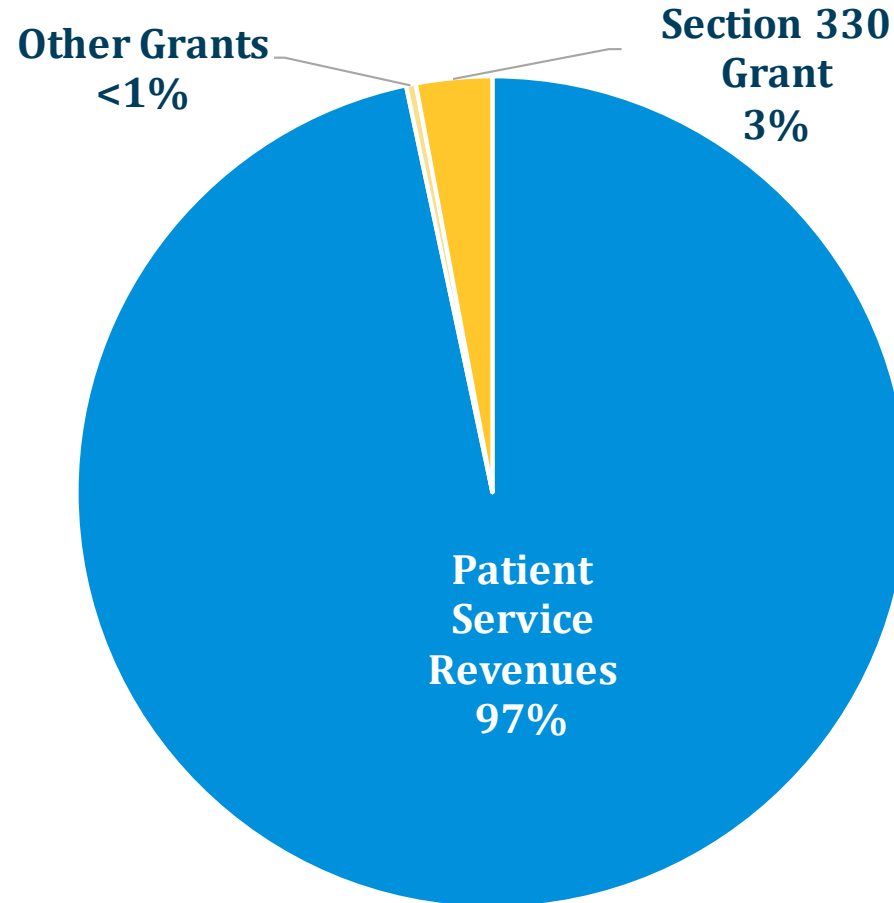
Notes:

- Expenses are apportioned based on a combination of residency square footage and resident visits
- Continuity clinic expenses are separated by operations and administration costs
- Residency overhead is a small component of other education costs



Distribution of Revenues Associated with Residency Training (AY 2018-2019)

Total Median Revenues Per Resident: \$71,510



Note:

- Revenues are apportioned based on number of resident visits to total continuity clinic(s) visits

DME PRA ESTIMATE

Year	25 th percentile	Median	75 th percentile	Number of THCs
2018-2019	\$149,321	\$178,499	\$224,672	50
2022-2023	\$175,358	\$209,623	\$263,846	50

Note: GW used a 4.1 percent annual inflation rate from the CPI for Medical Care for AY 2019 through AY 2023.

INDIRECT MEDICAL EDUCATION (IME) COSTS

- **GW undertook three approaches to developing an IME payment formula**
 - Comparative analysis using UDS data for THCs and non-teaching health centers - analysis did not yield empirical findings for IME cost differences
 - Small comparative analysis of participating THCs and paired non-teaching health center site: very limited sample met study criteria and was willing to participate. The analysis did not inform an empirical approach to developing an IME payment formula
 - Qualitative interviews with participating THCs indicated that some IME costs exist and are unaccounted for, however these costs vary greatly across THCs and health centers and did not provide sufficiently robust evidence to designate an IME adjustment
- **GME Expert Panel Meetings convened by GW**
 - Some evidence of outpatient IME costs associated with “chaos factor” of training residents
 - Despite the original intent of the statute, the concept of traditional IME may not align with HRSA’s needs
 - GW is identifying additional options that are consistent with HRSA’s mission and priorities, including approaches that are based on performance, quality, and outcomes